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ABSTRACT

One of 10 documents developed for preschool programs for handicapped children, the manual focuses on a transdisciplinary training, assessment, and consultation model. Advantages of the approach include the teacher becoming an integral part of the diagnostic process, the clinical staff becoming an integral part of the teaching process, and the more efficient management of time. The introductory chapter defines "transdisciplinary" and discusses the process of assessment in question and answer format. The second chapter examines parent and staff roles and responsibilities, and outlines evaluation and interview topics. The next chapter, on training, assessment, and consultation, focuses on training activities for assessment and the role of consultation between team members and teachers. The final chapter provides a 2 year implementation plan with descriptions for methods of using the transdisciplinary process in screenings and preentry evaluations. Appendixes provide sample job descriptions and a transdisciplinary report. (DB)

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THE TRANSDICIPLINARY TRAINING, ASSESSMENT AND CONSULTATION MODEL

Preschool Program: A Regional Demonstration Porgram for Preschool Handicapped Children

Carol S. Eagen
Kathleen Petisi
Amy L. Toole

Edited by Kennith Goin
Illustrations by Nancy Creegan

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FOREWORD

During 1978, the Regional Demonstration Program for Preschool Handicapped Children began work on a curriculum model, which included developing the approach described in this book. Before 1978, the model used in our preschool program had been "multi-disciplinary." A speech therapist and psychologist evaluated each child individually, wrote reports, and then presented findings to the rest of the staff. Unfortunately, the reports were sometimes redundant and at other times in total disagreement regarding the child's condition. There were often gaps in these reports in the information that the Central-Intake Committee needed to make decisions regarding placement of incoming children. Moreover, classroom teachers frequently found the reports of no practical use in a daily teaching situation. In short, the approach did not provide enough information about children and families to support parent and teacher intervention adequately.

In 1978, the Handicapped Children's Early Education Program (HCEEP) provided funds for a demonstration project in our preschool. The clinical staff (a psychologist, speech therapist, and social worker) hired for the new program decided to evaluate various ways of using a "team concept" to provide services. Ultimately, the "transdisciplinary" approach used by the Family Centered Resource Project in Reading, Pennsylvania, was reviewed and adopted for use in our environment. We modified it so that it became an <u>educationally</u> oriented program for mildly to moderately handicapped three- to five-year-old children.

By the spring of the first year, the advantages of the new approach were clear, and the staff was anxious to fine tune it for their particular needs. Thus, an all-day workshop was held in which problems were

presented and, in most cases, resolved. The result of this effort was a manual. It was distributed to all of the staff in the fall of the next school year, and everyone was trained in using the new modified approach.

During this second year, meetings were held to discuss further changes. At the end of the school year, an all-day workshop was again held to make final revisions. The manual which follows is the result of these two years of planning, pilot-testing, discussing, and revising. It is written in a style which is concrete and specific so that other programs may use it to develop their own transdisciplinary approaches. Among the advantages we have reaped from this approach to services are:

1. Each team member gained an understanding of the other's philosophy, style, and abilities.
2. The teacher became an integral part of the diagnostic process.
3. The clinical staff became an integral part of the teaching process.
4. The parent became an integral part of both processes.
5. Time was managed efficiently.
6. Child testing was reduced while information regarding the child's learning style and abilities increased.
7. A classroom-centered approach to teaching and therapy allowed a child to learn in a child-centered environment.
8. All members of the team, including parents, began to learn from each other.

It is hoped that other preschool programs will benefit as our staff has from the use of this model.

PREFACE

The Transdisciplinary Training, Assessment, and Consultation Model was developed for a classroom program of three- and four-year-old mildly to moderately handicapped children. Implementing the model requires a team of professionals consisting of a special education teacher, a psychologist, a social worker, and a speech and language therapist. The teacher is the primary facilitator within this team. However, programs in which physical therapists, occupational therapists, nurse practitioners, psychiatrists, or other professionals are employed and in which the primary facilitator of the child's educational program is other than the teacher may find the model very workable.

Chapter I is an introduction to the transdisciplinary process. It includes information on goals, advantages, key concepts, etc.

Chapter II describes the roles of the professionals and parents using the transdisciplinary process.

Chapter III describes the training activities which help make the process work and the way a transdisciplinary team conducts a diagnostic evaluation. The critical role of consultation between team specialists and the teacher is also described.

Chapter IV addresses the two-year implementation plan. It includes a timeline of first- and second-year activities and a description of how the process may be used in screenings and pre-entry evaluations.

Figures within the manual are representative of forms that we use in the transdisciplinary approach. The figures can be used as is or adapted to meet the needs of individual programs.

This manual is suggested as a companion piece to training workshops in the transdisciplinary model. Intensive training workshops are available through the Regional Program for Preschool Handicapped Children.

ACKNOWLEDGEMENTS

We wish to acknowledge all of the teachers and clinical staff of the Regional Demonstration Program for Preschool Handicapped Children who gave of their time and efforts to develop the Transdisciplinary Model in the hope of serving the total needs of children and their families better.

We would also like to express thanks and appreciation to Helen Smith, Ruth Barsich, Rosemary DiRubba and Lucy Yonetti for their assistance in the typing and retyping of this and many other Regional Demonstration Preschool Program manuals.

Special thanks to Dr. Paul Irvine, Director of Special Education, and Dr. Donald Coe, Assistant Director of Special Education, and to the administration of the Putnam/Northern Westchester Board of Cooperative Educational Services for their support.

Carol S. Eagen

Kathleen Petisi

Amy L. Toole

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CHAPTER I

INTRODUCTION

What Is A Transdisciplinary (TD) Process?

It is an approach to evaluating a child's development. It relies on a team of professionals, paraprofessionals, and parents sharing their information, knowledge and skills with each other. For the process to work, there must be:

1. A willingness among those involved to work together to build a team.
2. An interest in and ability to teach others the techniques of one's area of expertise.
3. A willingness to learn the skills used by other disciplines represented on the team.

How Is Transdisciplinary Different From Interdisciplinary?

An interdisciplinary approach usually involves each professional assessing the child separately and recommending treatment, if necessary, to be provided by a specialist (Carter, 1970; Hasenstab, 1979). These plans are then coordinated through staff meetings, and schedules for providing the services are arranged. In the transdisciplinary approach, professionals assess the child together. They not only talk about their diagnostic impressions, they demonstrate their abilities to their co-workers. They also train the teacher as necessary in the intervention techniques of their fields so that he or she--rather than a specialist--actually intervenes with the children. Because the assessment is conducted by the group or team, preassessment training is necessary for all members of the team to ensure adequate collaboration and an understanding of each other's function.

What Are The Reasons For Using A Transdisciplinary Approach?

Preschoolers with special needs (such as vision, hearing, motor, speech, language, or social adjustment difficulties) often require services from a number of professionals. The way in which these services are made available influences their effectiveness in promoting the child's development. We believe that a good argument for the TD process is its team orientation. Its success depends upon creating an environment in which professionals and parents can work as a team. How can this environment be created? Researchers (Anastasiow, 1976, 1979; Gordon et al., 1975; and Hanes, et al., 1976) agree that several factors promote the effectiveness of early intervention programs:

1. Personnel possess a common philosophical orientation. This tends to free communication between staff members. A TD approach necessitates the forming of a team with a common philosophy.

2. Personnel are drawn from varied professional backgrounds. Goehl, et al. (1979), observe that a team seems to be effective in meeting the needs of handicapped children because it draws from so many professional circles: early childhood teachers, paraprofessional aides, speech and language therapists, social workers, school psychologists, supervisors, medical consultants. The training stressed in this model is, among other things, designed to keep team members apprised of relevant advances being made within various disciplines.

3. Assessment for a given child is completed in a short period of time and is thorough. In most interdisciplinary approaches, each professional involved sees the child individually and administers a test suitable for determining skills and abilities from the perspective of his or her discipline. For preschoolers, these assessments may have to be carried out over several weeks because of limited attention span.

Consequently, the professional can provide little in the way of direct services because most of his or her time is given to evaluating.

In the TD approach, all of the team works with the child simultaneously which reduces the time family, child, and professional spend in evaluation. This also eliminates redundancy which often occurs among the tests given by various professionals. In the Staff Development Handbook, A Resource for the TD Process (1979), Una Haynes and Dorothy Hutchinson state:

> The TD approach simply reduces the number of professionals needed to render separate, direct services to the child. In doing this, the TD team reduces the compartmentalization and fragmentation of services to the child and his family (page 3).

4. The administration supports changes which improve delivery of services. This assumes that the administrator realizes that a program or procedure is ineffective and is willing to intervene by hiring new staff or training personnel to perform new functions (Miles, 1961; Abbott, 1965; Hanson, 1979).

What Are The Advantages Of A TD Approach?

The advantages for the child are many. First, he or she is assessed in a relatively short amount of time since all the professionals work together rather than separately. This cuts down on test redundancy. For example, a psychologist and speech therapist are both interested in language development, albeit for different reasons, and when they examine the child together they are both gathering the information they need--only in a shorter period of time.

Second, the child is more likely to be seen in his or her totality. The team members see him or her not only from their own professional viewpoint, but from the perspective of others on the team.

Third, since parents and teachers are part of the team, home and school behavior can be considered in the assessment. This means that the goals and educational objectives developed for each child are more likely to be well-suited for promoting that child's overall development.

Fourth, the child's ability to imitate (in terms of language, motor, cognitive, and personal-social skills) can easily be evaluated because of the "arena" aspect of the assessment (see p. 37).

Fifth, the process makes it possible to obtain a differential diagnosis of the child's needs easily.

Parents also benefit when the TD approach is used because they receive information about their child from each member of the team, and they can observe each team member conducting an assessment of the child in his or her area of expertise. They also receive a comprehensive description of the child's special developmental needs. Perhaps most important of all, the parents participate in the assessment and help develop their child's educational program.

Why Would Professionals Want To Conduct An Assessment in This Way?

In some ways, the professionals benefit from this approach as much as the child. It saves them time. Because the parent and teacher participate, it gives them more information about the child more easily. It gives them the support of the group in solving difficult problems. It helps them understand the roles of the other professionals in the

group, and thus it reduces competitiveness and increases respect for other disciplines. Perhaps most important of all, teachers receive extra help in working with special needs children.

What Difficulties May Be Encountered With This Approach?

Team members may not initially trust the knowledge and expertise of the other professionals. And, they may be unprepared for such an approach because most university training is unidisciplinary. Administrators can eliminate both of these problems by providing staff training across disciplines, by encouraging members to share their expertise with the rest of the team, and by hiring clinicians and teachers who are open to such an approach.

Parents may find it difficult to participate in the assessment with professionals involved. This problem can be remedied by a comprehensive program of parent involvement. Teachers should, in fact, conduct a parent group meeting to orient them to the TD process and to introduce them to each team member. These members should be available to describe their roles if parents inquire.

What Are The Key Concepts In The TD Approach?

These concepts, which are described in detail in the next two chapters, include:

1. The Team -- a unit of people, each of whom possesses a common understanding of the TD philosophy for evaluating children's development.
2. Training -- a means of helping team members function together effectively.
3. Role Release -- the concept wherein a professional is willing to train others in the skills of his or her discipline.

4. Arena Evaluation -- an approach to assessing children with special needs.

5. Consultation -- a method through which other professionals can support the teacher in intervening with the special child.

How Does One Begin To Use This Approach?

One of the first steps is to train a group of appropriate professionals. This is the topic of Chapter 3.

Who Precisely Is This Manual For?

It is for staff members of early childhood education programs and for consultants retained by such programs for the purpose of assessing the development of pupils. This particular program was developed for those working with a preschool population, though the model could be used by those serving any age group of handicapped children.

This manual is particularly for:

1. Programs run by administrators who will support the transdisciplinary concept and are willing to allow time for staff training.
2. Those who feel comfortable working together as a team.
3. Those committed to facilitating the development of the child through the classroom teacher and family intervention rather than through direct intervention by particular specialists (e.g., speech therapists, psychologists).
4. Those willing to train others in their areas of expertise.
5. Those able to follow an exact timetable which requires their presence on particular days for training, assessment, and consultation activities.

How Much Time Does It Require Of The Professionals Involved?

At least one day per week per twenty children. The team which may include a social worker, psychologist, speech therapist, teacher, physical therapist, occupational therapist, nurse practitioner, psychiatrist or other professionals work together on assessments, parent conferences, and consultations.

When Are The Children Actually Evaluated?

The chart below explains the schedule we have used. If the evaluation staff is hired for one day per week and there are no more than ten children in the program, assessments and some consultations (with parents and teachers) can be completed by the end of November. If there are twenty students in the program, we suggest the clinical staff be hired for two days per week. If this is not possible, diagnoses of children can be prioritized so that the first ten children are diagnosed by the end of November and the second group of ten by the end of February.

ASSESSMENT CYCLE

	Week 1	Week 2	Week 3	Week 4
September	Staff Training	Assessment of 2 children	Parent Conferencing	Staff Training
October	Assessment of 2 children	Parent Conferencing	Child Observation	Assessment of 2 children
November	Parent Conferencing	Assessment of 2 children	Parent Conferencing	Assessment of 2 children

The cycle is repeated when additional children are in need of assessment. The consultation model is followed for the remainder of the year until graduating children are in need of post-assessments.

What Does "Child Observation" Refer To?

Team members observe the child in the classroom environment since it is often difficult to gain sufficient information from formal assessments of preschool children. Team members, when observing children in the classrooms, can gain additional information about behavior such as: interaction with peers, reactions to transitions, play, attention span and spontaneous verbal interaction. This data can be used in developing comprehensive individualized educational plans.

CHAPTER II

STAFF ROLES

All activities undertaken in this approach are ultimately designed to help professionals provide the best level of services possible to each child in their program. In this chapter, we will examine the components of this approach first by identifying the people who are normally involved with the assessment of a child. Second, their roles in the process will be outlined.

THE PEOPLE

Those involved in assessing a child are usually a core staff of professionals and the child's parents. The core staff usually consists of a psychologist, a speech/language pathologist, a social worker, and the teacher. Various consultants may also be a part of the assessment if screening data suggest that particular developmental areas outside the expertise of the core staff be evaluated. Although the program's administrator is usually not part of the team that assesses the child, he or she plays an important role in making the whole process work.

THEIR ROLES

The Administrator

This person is responsible for bringing the core staff together so that they may meet each other and explain their philosophies and their work. This is done during an initial training workshop (p. 30). During

this workshop, the administrator sets a tone of cooperation among the disciplines and emphasizes the goal of the transdisciplinary process: working together and learning from each other. Because he or she has had a part in selecting the members of the team, the administrator is in a position to display his or her confidence in each member's ability--thus planting the seed of confidence that the whole team must eventually have in each of its members.

The administrator is also responsible for providing and organizing time for inservice training workshops (see Figure 6) and other activities that help build the "team." For example, the administrator must make arrangements for the teacher to have time away from the classroom to participate in the workshops.

At the end of the year, the administrator evaluates the effectiveness of the process. He or she may use questionnaires, individual and group conferences, and other means to find out those things in need of change and those activities that work.

The Speech Language Pathologist (SLP)

This person works together with the psychologist during the actual evaluation. He or she is primarily concerned with the child's communication skills and in making recommendations for intervention.

The SLP usually analyzes three language components--content, form, and use--from the information obtained by the psychologist through developmental/intelligence tests. Figure 1 indicates specific areas in which the SLP and the psychologist are working together. The chart follows the sequence of the subtest on the Stanford-Binet Intelligence Test, Form L-M.

OVERLAP SKILLS CHART

FIGURE 1

Stanford Binet	Fine Motor	Visual Perception	Eye-hand Coordination	Gross Visual Acuity	Spatial Relationships	Test Behavior	Test Orientation	Impulse Control	Imitation	Language	Comprehension	Receptive Vocabulary	Follow directions	Object Permanence	Relate to pictures	Relate to objects	Relate to spoken words	Visual Memory	Expressive Ability	Speech (Articulation)	Oral Vocabulary	Word Finding	MLU	Body knowledge	Auditory Memory	Oral Motion	Syntax	Relevancy	Gross Auditory acuity
Three Hole Form board	P/S						P/S				S																		
Delayed Response								P			S		P	S				P										P/S
Identify parts of the body		P		P/S							S				P/S								P					P/S
Block Building	P/S	P	P	P/S	P		P/S	P	P/S				P																P/S
Picture Vocabulary				P/S								P/S			P/S					S	P		S						
Word Combinations																	P/S			S	S	S	P/S		S	S	P/S	P/S
Identify Object by name				P/S							P/S	P/S	P/S		P/S														
Identify Object by use				P/S			P	P			P/S	P/S	P/S			P/S													P/S
Naming Objects		P		P/S			P				P/S					P/S				S	P/S	P/S			S				P/S
Repeating Digits							P	P	P/S				P/S							S				P/S					P/S
Obeying Commands							P	P			P/S	P/S	P/S		P/S									P/S					P/S
Stringing beads	P	P	P	P/S			P	P	P/S				P/S																
Picture Memory		P		P/S			P	P			P/S	P/S	P/S		P/S		P			S	S	S		S					P/S
Coping Geometric Designs	P	P	P	P/S	P		P	P	P			P/S																	
Comparison of balls		P		P/S	P		P				P/S	P/S	P/S																
2 Piece Picture Puzzles	P	P		P/S	P		P						P/S																
Discrimination of animal puzzles		P		P/S			P	P			P/	P/S			P														
Sorting Buttons	P	P	P	P/S	P		P	P	P/S	P/S	P/S																		
Comprehension (Verbal)							P/S				P/S		P/S					P/S		S	P/S	S	P/S			S	P/S	P/S	P/S
Comparison of sticks (length)		P		P/S	P		P	P			P/S	P/S	P/S																P/S
Naming objects from memory				P/S			P	P			P/S	P/S	P/S		P/S	P/S	P			S	P/S		S		S				P/S
Opposite Analogies							P/S	P/S			P/S	P/S			P/S					S	P/S		S		S				P/S
Pictorial Identify		P		P/S			P/S	P/S			P/S	P/S			P/S	P/S								P/S					P/S
Discrimination of forms		P	P	P/S			P/S				P/S	P/S																	P/S
Memory for sentences							P/S	P/S		P/S		P/S								S					S				P/S
Aesthetic Comparision		P/S		P/S			P/S			P/S	P/S				P/S														P/S

OVERLAP SKILLS CHART

Stanford Binet	Fine Motor	Visual Perception	Eye-hand Coordination	Gross Visual Acuity	Spatial Relationships	Test Behavior	Test Orientation	Impulse Control	Imitation	Language	Comprehension	Receptive Vocabulary	Follow directions	Object Permanence	Relate to pictures	Relate to objects	Relate to spoken words	Visual Memory	Expressive Ability	Speech (Articulation)	Oral Vocabulary	Word Finding	MLU	Body knowledge	Auditory Memory	Oral Motion	Syntax	Relevancy	Gross Auditory acuity
Response to pictures (level 1)		P/S		P/S			P/S								P/S					S	P/S	S	P/S			S	P/S	P/S	P/S
Pictorial Similarities and differences		P		P/S			P/S	P/S		P/S				P/S															P/S
Materials							P/S			P/S										P/S	P/S		P/S			S		P/S	P/S
Three Commissions				P/S			P/S	P/S		P/S				P/S															P/S
Comprehension III										P/S		P/S					P/S			P/S	P/S	P/S	P/S		F/S	P/S			P/S

"P" signifies skills that the psychologist assesses.

"S" signifies skills that the speech and language therapist assesses.

Free Play:

Relevancy
Spontaneity
Integration
Attention span
Distractibility

The child is also observed during play and interaction with others in the classroom. When appropriate, prelanguage skills and nonlinguistic communication abilities are assessed through observation of the child's interaction with others.

The following outline details the evaluation usually conducted by the speech and language pathologist. There are essentially six overlapping aspects to the evaluation:

I. Pertinent History (as it relates to the speech/language disorder)
   - A. Medical history
   - B. Family history
   - C. General description of child's behavior, likes and dislikes, as well as impressions of child's interaction with family members

II. Behavior During Testing
   - A. Attention span
   - B. Eye contact
   - C. Use of toys
   - D. Response to adults

III. Auditory Skills

To determine if an auditory disorder is present or if formal auditory testing is needed, the following areas should be considered:

   - A. Child's behavior; hesitancies in speech, inappropriate answers to questions, difficulty in following sequence of directions.
   - B. Speech and language skills
   - C. History

IV. Speech Skills

Intelligibility of speech should be examined, and a determination of factors interfering with intelligibility should be made. The Goldman-Fristoe Test of Articulation might be administered.

V. Peripheral Speech System

The mechanism of speech should be examined, and structural and functional disorders noted.

VI. Language Skills

Prelanguage as well as language skills (including content, form, and use) should be evaluated. A language sample should be taken for this purpose (see Figure 2). The following (as well as other) tests may be used in the evaluation:

A. Peabody Picture Vocabulary Test (receptive vocabulary)

B. Illinois Test of Psycholinguistic Abilities subtests (receptive and expressive language abilities in three to five-year-olds)

VII. Other Agency Evaluations from Audiologist, Neurologist or Otolaryngologists

All of this information, in combination with pertinent historical information (obtained primarily by the social worker from the parent, teacher, or other agencies) is used in forming a diagnostic impression and in making recommendations for intervention.

The Psychologist

This person focuses on the child's present level of intellectual and perceptual functioning, his or her reaction to a structured test situation, and social-emotional development (especially as it pertains to interaction style in a learning situation).

FIGURE 2

EXAMPLE OF LANGUAGE SAMPLE

	Child utterance	CA : 3-5 9/22/80	Categorization of utterance
1.	**baby** car/		describes situation
2.	oh she stuck/		describes situation
3.	open/da/door/		command (to doll)
4.	how she get in//		request for information
5.	oh night here/		request for information
6.	how she sit down//		request for information
7.	sit down/		command (to doll)
8.	how her drive//da /		request for information
9.	she fall down/		describes action
10.	open the door//		request action (command to clinician)
11.	right here//		seeks verification
12.	you take her outOK//		(tag question) request for action
13.	put her back in/		request for action
14.	daddy/		response to question "who"
15.	where mommy//		imitation of "where's the mommy"?
16.	mommy with the daddy/		response to question
17.	**everybody go in the back/(/ebai/)		describes action
18.	lay down in the back/		describes action
19.	to store/(/duds/)		response to "where is he going"?
20.	how do man sit down//		request for information
21.	bend him legs//		imitation of "bend his legs"
22.	how him fit//		request for information
23.	how him drive//		request for information
24.	/da/man driving/ (/daian/)		describes situation
25.	she want to go in the car/ (/ga/=car)		statement of feeling
26.	go open the trunk/ (/fʌnk/=trunk)		describes upcoming action
27.	how open the trunk//		request for information
28.	/a//biga/toothbrush/		labels item
29.	fire engine truck/ (/faɪɹ ɛʃʌk/)		labels item
30.	I pickin out all/da/ people		describes action
31.	how da wheels go//		request for information
32.	pick out other car/		request for action (command to clinician)
33.	this car (/dI/=this)		labels item
34.	two cars/		labels item
35.	/hæ/this//		request for information
36.	the man fall		describes action
37.	pick the man up/		requests action
38.	the man still falling down/		describes action
39.	nothing in there/		describes situation
40.	airplane/ (/ɔ paIn/)		labels item
41.	**go up and down**		describes action
42.	**helicopter/dubae//**		request for information
43.	what/I/here// (/I/=in)		request for information
44.	nothin/		response to above
45.	what/I/here// (/I/=in)		request for information
46.	open this/		requests action
47.	**bae** washcloth for wash/		labels object and function
48.	comb our hairs/		labels object and function
49.	cup for drink/		labels object and function
50.	a watch for daddy go work/		labels object and function
51.	this a bag for daddy to to work/		labels object and function
52.	fix the man/		requests action (command to clinician)

53.	combin your hair/	response to question
54.	the wheel goin/	describes action as pushing car
55.	the man fall down again/	describes action
56.	no falling	describes action
57.	I fix the man/	describes action
58.	oo- a telephone for call/	labels object and function
59.	**phone**ringing/	describes action/situation
60.	nobody there/	describes action/situation
61.	nobody on the phone	describes action/situation
62.	play/be/the car now//	requests permission
63.	right you back/	describes location of toy
64.	the big car/	labels object
65.	why take the people out//	request for information
66.	this a mommy/	labels doll
67.	the mommy go in truck/	describes action

**Refers to unintelligible utterance

SUMMARY

Language Production: Approx. MLU 3.3 - Stage III (approx. age 3 yrs.)

CONTENT - generally appropriate during language sample, however exhibited difficulty labelling objects and describing pictures during psychological evaluation

FORM - Grammatical morphemes:
1. irregular past tense - omitted
2. possessive marker - not observed
3. uncontracted copula (is blue) - omitted
4. articles (a,the) - exhibited occasionally

Sentence types:
1. No auxiliaries present in declaratives or interrogatives
2. How, why, questions, omits "dummy" do
3. Tag questions (e.g., "OK")

Pronouns:
Occasional confusion of he/she, him/her
I, you, me, my - appropriate

Stage III forms emerging, imcomplete at this time: occasional stage IV construction (e.g., articles)

USE - Uses language to request information, action, permission describe ongoing action/events

Language Comprehension:

SYNTACTICAL - Inconsistent responses to wh-questions
Comprehends reversible active sentences, plurals
Difficulty with possessives

LEXICAL - Receptive vocab. on PPVT (a) - 2 years 7 months (delay 10 mos.)
Inconsistent knowledge of relational concepts

This assessment is designed to describe the child's preferred or best developed mode for learning as well as areas of weakness for the purpose of appropriate educational planning. The need for referral to other specialists for visual, audiometric, physical, and other evaluations is also considered.

The psychologist evaluates cognitive and intellectual functioning in two ways. First, he or she observes the child in a play situation and, second, administers structured tests to measure cognitive development.

I. Observation

The child is placed in a situation with a box of toys appropriate for an age range of six months to five years. These toys should be those most likely to stimulate spontaneous utterances. Examples are: a surprize box, a doll, a bottle, a bed, a shoe box. The shoe box may be filled with small toys so the child can demonstrate recognition of objects. These toys may include cars, planes, small blocks, doll families, tables and chairs, and eating utensils.

The purpose of this part of the assessment is to evaluate the child's:

A. Ability to act as initiator

B. Play style

C. Language in a spontaneous situation

D. Ability to interact with examiner and/or parent in a child-oriented play situation as compared to a task-oriented, examiner-initiated, formal testing situation

II. The Tests

The tests used are designed to determine the child's cognitive level of functioning. They may include those listed below and others.

A. The Bayley Scales of Children's Development is used for children from birth to three years.

B. The Stanford-Binet is used primarily for the child with verbal skills within the three-to-five-year age range.

C. The Leiter International Performance Scale is given to deaf, hearing impaired and nonverbal children to determine intellectual abilities without using language.

D. The McCarthy Scales of Children's Ability is administered to children from three to five and the Wechsler Preschool Primary Scale is administered to children functioning within the four- to five-year age range to help determine school-age placements upon graduating from the program.

The Social Worker

This person is concerned with the interaction of the child and the family and the way this affects the child's development. At the assessment, he or she is responsible for introducing the parents and the team to each other and for explaining the function of each examiner (psychologist, speech pathologist, and teacher) to the parent. He or she also schedules the conference when the team members will review their diagnosis of the child's needs with the parents. Finally, the social worker obtains any evaluation reports on the child that have been completed by other agencies.

The role of this person in the evaluation includes conducting an interview with the parents which covers the following:

I. General Information

A. How did parent find our program? (The social worker should explain at this point, the details of the program: personnel,

hours, services, required medical forms, need for releases, forms which will be sent home, monthly meetings, snack money, explanation of the Individualized Education Plan (IEP).)

B. What do you see as the child's greatest difficulty?

C. What have you done to solve the problem or get assistance?

D. Who has been helpful--agencies, individuals, organizations?

E. What do you want the child to acquire or gain from the program?

F. What would you like for yourself from the program?

G. Is your parenting style the same or different with this child as with your other children? Please give examples.

H. Do you anticipate that your child will need special attention when he or she reaches school age? If so, what type?

I. How available are you or your spouse to participate in the program? (The teacher should describe the variety of parental participation activities available and extend an invitation for the parents to phone personnel in the program as necessary.)

NOTE: The above is an <u>ideal</u> interview. Naturally, omissions and additions are made spontaneously according to the dynamics and interactions between the parent and social worker.

II. Birth and Pregnancy

A. What was your pregnancy like?

1. Duration
2. Illnesses
3. Medication taken
4. Previous miscarriages
5. Child's birth order

B. What was the birth like?

1. Anesthesia
2. Length of labor
3. Toxemia
4. PKU (Phenylketonuria)
5. Oxygen or forceps used

III. Developmental History

A. What was early development like?

1. Was the baby breast or bottle-fed?
2. Was there difficulty with sucking or swallowing?
3. What were the sleeping habits of the infant?
4. What were the crying and eating conditions? Any allergies?
5. Were there fevers or convulsions? Any medications?
6. Were crib toys, mobiles, etc., available? What was child's response?
7. Were there any separations from mother?
8. Were there other early traumas, e.g., ear infections? Is child startled by noises?

B. What about milestones and habits?

1. When did the child sit up, crawl, walk, begin teething, say first words, use two-word combinations?
2. Were there specialist evaluations, hospitalizations?
3. What style toys did he or she prefer?
4. When was he or she toilet trained?

5. How much time does he or she spend with TV? With you reading?
6. Who is child emotionally closest to in family?
7. How often is child with other people? Who are they?
8. Has child been on trips?
9. What is the neighborhood environment like?
10. Where does the child sleep?
11. Does child wet bed or have nightmares? Any other fears?
12. Does child have chores?

IV. Family Structure

At this point, the social worker asks the parent to provide information about all nuclear and extended family members. From this data, a genogram (see Appendix B and Figure 3) is constructed to provide a visual and factual description of how the child fits into the family system. The genogram is later shared with the family.

A. Parents

1. What are their names, ages, educational levels, occupations, medical problems?
2. Is there a history of learning problems?
3. Were parents previously married?
4. Are other languages used in home?
5. How often have parents and family moved?
6. If divorced, for how long? What are visitation arrangements?

B. Grandparents

1. Maternal

a. living or deceased?

b. if living--where? medical problems? how often in contact?

c. if deceased--when? what from?

2. Paternal

a. living or deceased?

b. if living--where? medical problems? how often in contact?

c. if deceased--when? what from?

C. Child's Siblings

1. What are their names? Ages? Any medical or educational problems?

2. How does child get along with siblings?

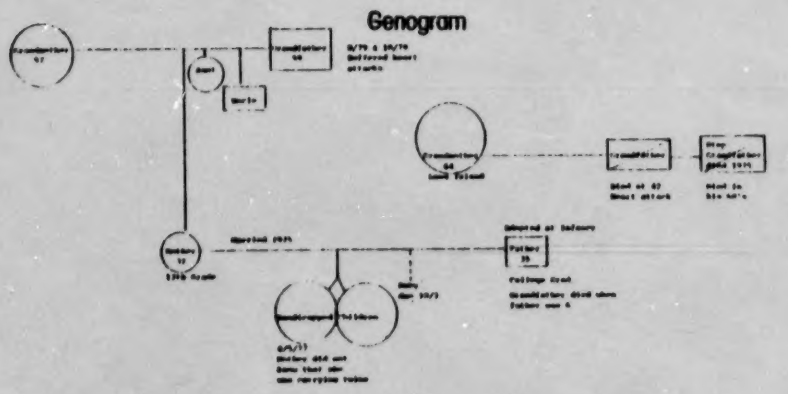
FIGURE 3

Sample Genogram

Instructions for completing a genogram:

A genogram is a map of the family. Facts and information given by the child's parents during the interview are included.

1. Men are show as squares, women are shown as circles.
2. Start at the bottom of the horizontal page.
3. Show the child, date of birth, any factual medical or birth information.
4. Chart the child's siblings, parents, aunts and uncles and grandparents.
5. Add dates of birth, deaths, marriages and divorces.
6. Record any factual medical conditions, diagnosed learning problems, and cause of deaths for the family.
7. Foster children or nonrelated family members are noted with broken lines.



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The Teacher

The teacher's role is to provide information to other members of the team regarding the child's functioning in the classroom. More than any of the other professionals, he or she has observed the child's social interactions, language and cognitive abilities, and overall behavior. He or she is familiar with learning style, attention span, and reaction to environmental changes--all of which have a bearing on the approach the assessment team should use. By the time of this evaluation, the teacher has often informally assessed the child's social-emotional, speech and language, cognitive and motor functioning and is in a position to direct the team to areas he or she feels are in particular need of examination.

During the team assessment, the teacher may check the developmental level of home skills with the parents by using a developmental checklist.

The teacher's role in the process covers three major areas.

I. Before the Team Evaluation
   - A. Observe the child in the classroom
   - B. Identify potential problem areas

II. During the Evaluation
   - A. Familiarize team with child's learning style, potential problems
   - B. Work with parents to obtain developmental level of home skills

III. After the Evaluation
   - A. Develop Individualized Education Plan (IEP) with help of other professionals
   - B. Make recommendations for parent involvement
   - C. Receive consultation from team members

Consultants

Psychiatrists, neurologists, pediatricians or pediatric nurses, and physical and occupational therapists can be used as consultants according to the individual needs of the child. The team may feel it is necessary to use consultants, not only during assessments, but during parent conferences, staff training, or child observations.

Parents

Before the assessment. Any intervention program which is successful with children usually tries to involve parents in its activities (Gordon et al., 1975; Hanes et al., 1976). In the transdisciplinary model, therefore, parents are considered team members. The teacher encourages them, at the parent orientation meeting at the school, to become involved. At this meeting, parents who have been in the program during the previous year relate their experiences. During the first month of school, a meeting is held to introduce parents to the transdisciplinary model. The critical points to explain at this meeting are:

- A clinical team is available to evaluate children and provide consultation and recommendations to teachers and parents.
- Direct therapeutic services, with the exception of speech and language therapy, are not available. (This will vary, depending on your school.)
- Team members have been oriented to specific aspects and testing procedures of the other disciplines.
- An "arena evaluation" will be held in which parents, the child, and team members are present.

- Parents are encouraged to provide important family and child developmental information to the team during the assessment.
- Parents will be involved in developing their child's individualized educational program.
- Recommendations will be given, after the evaluation, for parent involvement which may include:
  - classroom observations
  - attendance at small special-interest parent groups
  - home training
  - participation in parent volunteer program

During the assessment. Parents are interviewed for basic information about the child. They are encouraged to reveal their concerns and hopes for their child during the school year. Their presence during the evaluation makes it easy for the examiners to observe parent-child interactions.

The parents will act as interpreters during the assessment for a child who is nonverbal, has a severe articulation problem, hearing impairment, is a toddler, or is severely developmentally delayed.

After the evaluation. The parents participate in a conference designed to familiarize them with the results of the evaluation (see p.40) and their suggestions for goals to be written into the child's individualized educational plan are encouraged. The conference is often the first step in supporting parents in accepting their child's needs and differences. Parents may agree to participate in further individual conferences or small-group parent meetings based on their needs. Parent observations in the classroom are scheduled and parents may be asked to participate as a classroom volunteer.

Throughout the year, parents may receive guidance from the team. Team recommendations are often made for parent-child play. The value of play is explained as a means of parent-child interaction on the child's level to stimulate language, cognitive, social-emotional, motoric, and perceptual development. The team may find it helpful to initiate a program of home training with certain parents. Often, home training will be instituted to encourage consistency between the home and classroom program and to encourage parent-child interaction. Weekly prescriptions (see Figures 4 and 5) are written by the teacher with team consultation. Play is incorporated into the prescriptions. Successful experiences are encouraged by choosing an activity that the child can do.

FIGURE 4

INSTRUCTIONS FOR WRITING WEEKLY PRESCRIPTIONS*

1. Choose an activity which meets the parent's concerns about the child at home. It is recommended that an achieved skill be chosen when the focus is positive reinforcement, parent-child interaction, or developing confidence in the child.

2. Choose vocabulary to suit the parent's ability when necessary.

3. Model the activity with the child.

4. Have parent and child practice the activity in front of you. Praise efforts of parent and child.

5. Discuss:
   when task will be done each day;
   where material will be kept;
   who might be involved;
   what to do if it doesn't work;
   how to reinforce the child's cooperative behavior.

6. Write the basic goal in simple behavioral-objective terms. Note the number of times per day the activity will be directed.

7. The procedural steps are written using a task approach. Outline specific steps that the parent will take when conducting the activity.

8. A behavior chart is written to include:

   - days of the week
   - number of times per day
   - listing of the child's progress (needs help, no help needed, or action that is noted)

9. Summary comments are written to provide the parent with additional information that me be necessary.

*This prescription format is based on the approach of the Portage Project Model (Shearer and Shearer; 1974). Samples for these prescriptions can be found in Classroom Directed Home Training Activities (Jones; 1980).

FIGURE 5

Parent Recording Sheet

Child's Name:_____ Date Initiated:_____

Teacher:_____ Credit: Yes____ No____

Developmental Area: SOCIAL (Gross Motor)

Basic Goal

_____ will play patty-cake
(child's name)

with Mom and Dad.

Steps and Procedures

1. Sit facing another child with _____ in your lap.
2. Hold your hands over _____'s to pattern his/her moves. Stop helping when _____ begins to clap alone.
3. Say words slowly and clearly. Start with 1 line from those on the verse which follows. Each day, add 1 line more.
4. Play twice each day.

Verse:

1. Patty cake patty cake Baker's man. (clap) (clap) (hit other child's hands 3 times)
2. Bake me a cake as fast as you can. (hit other child's hands 2 times)
3. Roll it and pat it and mark it with (initial). (draw in air with finger)
4. And put it in the oven for _____ and me. (clap 4 times)

Behavior Chart : There is space to mark for 2 play periods each day. When the child finishes 1, place an X in the box. If he or she needed help, circle the X. Check column if other child is used.

	I	II	Other child
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Materials Needed

None.

Summary or Comments

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CHAPTER III

TRAINING, ASSESSMENT AND CONSULTATION

In this chapter we will examine the transdisciplinary components, which ultimately lead to improved services for children. First, the ways team members are assisted in performing the responsibilities of their roles are discussed in terms of training. Second, the assessment of the child is addressed. And finally, post-assessment consultation activities of the team are considered.

TRAINING FOR THE ASSESSMENTS

Initial Training Workshop

This event, organized by the administrator, is the first step in the transdisciplinary training process. At this meeting, the team members (except for parents) review their roles for the other members of the group in half-hour presentations. They may cover any of the material discussed in Chapter II (Assessment Roles) as well as their philosophy and approach to identifying handicapped children. The classroom teacher is encouraged, for example, to describe the daily routine which is prepared for young children and what kind of parent intervention he or she feels is important to incorporate in his or her classroom. The speech and language therapist might describe the language intervention model and theories which he or she adheres to as a therapist. The therapist might also describe the place the child's language and remedial strategies occupy in the total classroom intervention model. A psychologist might describe the theories of child intellectual development from a Freudian, behaviorist, develop-

mental, or Piagetian perspective.

This workshop is the beginning of role extension, a process which should be used by the team throughout the year. Role extension refers to the professional's quest for more knowledge which he or she will use in improving his or her evaluative and therapeutic skills. It means the professional must stay abreast of current research and other developments in his or her own field and use knowledge from other disciplines. It also means that he or she must try to gain knowledge of the skills used in evaluations by those in other disciplines. Role release is the other side of the coin. It is a process which "occurs when a team member releases some of the functions of his or her discipline to other team members, teachers or parents" (Hutchinson, 1976). In the transdisciplinary process, the clinical team members release some of the duties that would normally be their's in working with children to the classroom staff and parents.

Another important part of this first workshop is for members to decide as a team how they will conduct assessments. They need to decide on the responsibilities of each member. For example, the social worker may have the responsibility of contacting the parents to arrange for the assessment; the speech therapist collects appropriate toys; the psychologist provides test materials; and the teacher prepares the environment for the evaluation.

Inservice Training

The administrator can use this initial workshop to ascertain the group's training needs. The core staff is asked to complete the questionnaire shown in Figure 6. Then the administrator works out a schedule of

three or four training workshops based on this questionnaire to be held during the course of the year. Team members or consultants may lead the workshops. The sessions may be on any number of topics such as: the social-emotional development of the handicapped child; outside evaluation agencies; psychiatric, neurological, or medical consultations; and current research in professional disciplines.

FIGURE 6

STAFF NEEDS ASSESSMENT

The purpose of this form is to identify what inservice training activity would be most important to you this year, so that a staff training program can be developed based on your needs.

Please complete this questionnaire by placing a check in the appropriate box on the right-hand side.

	IMPORTANT			AIDE SHOULD ALSO ATTEND
	VERY	SOME-WHAT	NOT	
1. The emotional development of the preschool child	___	___	___	___
2. Language development of the preschool child	___	___	___	___
3. Cognitive growth of the preschool child	___	___	___	___
4. Methods of individualization--methods of teaching and record-keeping	___	___	___	___
5. Stimulating language in the classroom environment	___	___	___	___
6. Running parent groups	___	___	___	___
7. Training paraprofessionals	___	___	___	___
8. Ideas for arts and crafts activities	___	___	___	___
9. Materials sharing	___	___	___	___
10. Parent conference techniques	___	___	___	___
11. Review of the laws	___	___	___	___
12. Brainstorming sessions for ideas to use with particular children	___	___	___	___
13. Community agencies--who are they and what do they do?	___	___	___	___
14. Overview of other preschool programs for the handicapped	___	___	___	___

OTHER SUGGESTED TOPICS FOR TEACHERS, TEAM AND AIDES

SUGGESTED SPEAKERS

TD Evaluation Workshop

The administrator should also conduct an evaluation workshop during which the core staff can revise methods, decide on extensions of the team's role (such as conducting pre-entry TD assessments (see Chapter IV) and extending the role-release process), identify different assessment tools, or revise report forms, etc. A sample agenda for this workshop appears in Figure 7.

FIGURE 7

TRANSDISCIPLINARY EVALUATION WORKSHOP AGENDA

8:30 - 8:45	Coffee Discussion of day's activities
8:45 - 9:45	Small group to discuss TD approaches this year (large group breaks into teams) Revisions and extensions on: a. Assessment b. Staff training c. Consultation model (role release) d. Role extension e. Role of parents f. Leadership role g. Conflict resolution
9:45 - 10:30	Feedback from team and expansion of model
10:30 - 10:45	Break
10:45 - 11:30	Revise job descriptions based on feedback
11:30 - 12:00	Create timeline based on two years of implementation
12:00 - 12:15	Break
12:15 - 1:30	Discussion of current research that might affect the program's TD approach

THE ASSESSMENT

Definition

The assessment, in the transdisciplinary model, is an informal diagnosis of the child's developmental needs. It is usually conducted with a child who has been screened and is in an educational program. It involves, as stated earlier, a teacher, psychologist, social worker, speech pathologist, and parent(s).

Preparation

Prior to the assessment, the team or some of its members must do three things:

1. Develop a kit of materials which contain items necessary for the evaluation.
2. Familiarize the parents with the format and purpose of the evaluation (usually done by the teacher or social worker).
3. Hold a preassessment case conference during which the team examines screening and other pre-entry information and reports from other agencies. The team also is briefed by the child's teacher on classroom behavior (attention span, developmental level, etc.). Decisions regarding the assessment's focus are then made.

Assessment

The schedule for a normal assessment day is shown in Figure 8. The test environment is a small room with a table for the social worker, parent, and teacher to sit at while the parent is interviewed. The table is within visual distance of the child who sits on the floor or at a

FIGURE 8

TIMELINE FOR ASSESSMENT DAY

8:00 to 8:30		Review case, set up coffee, chairs, materials, kit, etc.
8:30 to 10:00		Evaluate child and conduct parent interview
10:00 to 10:15	-	Break, team presents parent and child information
10:15 to 11:15	-	Write reports
11:15 to 12:00	-	Lunch and case conference
12:00 to 12:15	-	Second case review
12:15 to 1:45	-	Evaluate child and conduct parent interview
1:45 to 2:00	-	Parent and child information is presented
2:00 to 3:00	-	Write reports
3:00 to 4:00	-	Case conference

child-size table with the psychologist and speech therapist. The space should be equipped with necessary toys and should be free from noise and intrusions. It is important for the child to have access to the parents at all times and that he or she not have to move throughout a large area. We call this special set-up an "arena evaluation."

Prior to formal testing, a variety of toys are provided to observe the child's behavior and language in a less structured, free-play situation. While this free play is in progress, the parent interview may be started.

During the one to one-and-a-half hour session, each person has specific responsibilities. The psychologist and speech therapist assess the child's skills and behavior while the social worker and teacher interview the parents. The psychologist usually administers an intelligence test. The Leiter International Performance Scale, Stanford-Binet, or Bayley Scales of Infant Development is used depending upon the child's developmental level. Simultaneously, the speech therapist observes and records information on the child's language and communication system.

Psychological tests are used primarily to identify the child's preferred or best developed mode for learning, as well as areas of weakness, for the purpose of appropriate educational planning. An IQ score may be obtained to compare the child to age peers. However, the major focus of the testing is on the qualitative information received because of the limits of the validity of the tests for a special-needs population.

After the Assessment

Post-Assessment Case Conference. Following the child's assessment, each team member writes a brief individual report and reads it to the

other members. At this case conference, all information obtained is synthesized, and goals and objectives are generated for the child's Individualized Educational Plan (IEP). The team decides if referrals to other agencies for additional evaluation or direct services are necessary. The extent of parent involvement is discussed, based on the social worker's and teacher's interview with the parents. If appropriate, prescriptions for the parents to follow at home should be generated.

The case conference, which includes all clinical team members and the teacher, may be initiated by the program administrator. The format of the case conference is as follows:

1. Each team member discusses information gained from the assessment.
2. The team members summarize their diagnostic impressions of the child and suggest recommendations.
3. The summary form (Figure 9) is completed cooperatively by all team members.
4. Long-term goals and short-term objectives are generated based on the above information, and the teacher records these directly onto an IEP draft form which is shared with the parents at the parent conference. Additions and deletions to the IEP are made, based on parent input.
5. The team determines the extent to which the parent would be helpful in working with his or her own child, and what possible prescriptive work, based on long-term goals, might be assigned to the parents.
6. The team identifies referrals which should be made to other agencies.

7. The team identifies which team members will hold the parent conference for reviewing the assessment results and sharing the IEP.
8. The team member who will call the parent and set up the appointment is identified.

Reports. Reports are written immediately following the case conference. Team members, who have discussed the child's needs, make recommendations individually and as a group. They complete the forms for their disciplines (Figures 10-13). Topics to be included under each heading are shown in the Figures. These forms are brief and should cover the major portions of the assessment:

1. The social worker provides a developmental history of the child based on the information gained from the parent interview. The social worker also draws a genogram at this time, which can be shared with the staff later, regarding family interaction. (See Appendix B.)
2. The psychologist includes information regarding the child's behavior during testing, cognitive and perceptual functioning based on the intelligence test given, and observation of the child's play behavior. Recommendations are made for providing assistance to the teacher in planning for the child's needs.
3. The speech and language therapist completes the summary form based on the child's language and speech skills, peripheral speech system, classroom and testing behavior, and any pertinent history regarding the child's speech and language development.
4. The classroom teacher completes his or her form based on the child's present level of functioning and classroom behavior.

Since all reports are written at the same time, each team member includes only information that is relevant to his or her discipline. The cover page for the Summary Report (Figure 9) is written by the team. The teacher and social worker complete the "educational history" section, and the psychologist and speech therapist complete the "diagnostic summary." The handicapping condition and recommendations are completed by the group. The recommendations contain long-term goals for the IEP.

Parent Conference. These are generally held on the week following the assessment. Both parents are encouraged to attend. At least two team members are present at the conference--the classroom teacher and the clinical team member identifed as "most appropriate" to participate in the conference. For example, if the child was found to be severely speech and language delayed, the speech pathologist would attend the conference.

During the parent conference, the following events occur:

1. The Summary (Figure 9) of the transdisciplinary assessment is discussed and shared with the parent. Individual reports (Figures 10-13) are shown to the parent.
2. The IEP is developed with the parent and his or her input is encouraged.
3. The child's classroom program is reviewed with the parents. The meetings that parents will be expected to attend, and any prescriptions that the staff would like the parent to work on at home (see Figures 4 and 5) are discussed. The parents are encouraged to suggest areas of the child's needs that he or she would like to work on at home.
4. Referrals to outside agencies are suggested at this time, and the parent is supported in making these contacts.

FIGURE 9

TRANSDISCIPLINARY DIAGNOSIS SUMMARY FORM

The social worker and teacher complete Educational History; the psychologist and speech therapist complete Diagnostic Summary. Handicapping Conditions and Recommendations are completed by the team.

STUDENT _____ DOB _____ CA _____

TEACHER _____ SCHOOL _____ AM __ PM ____

DATE OF EVALUATION _____ DISTRICT _____ COUNTY _____

DATE OF ENTRY _____

EDUCATIONAL HISTORY:

DIAGNOSTIC SUMMARY:

HANDICAPPING CONDITIONS:

RECOMMENDATIONS:

FIGURE 10

SOCIAL WORK DIAGNOSTIC SUMMARY

STUDENT _____ DOB _____ CA _____

TEACHER _____ SCHOOL _____ AM __ PM ____

DATE OF EVALUATION _____ DISTRICT _____ COUNTY _____

DATE OF ENTRY _____

SUMMARY SOCIAL DEVELOPMENTAL HISTORY:

General information gained from interview
Birth and pregnancy information
Developmental history
Medical information
Family structure--as relevant to child's educational program

IMPRESSIONS:

Statement of family needs as affected by child's handicap

RECOMMENDATIONS:

Consultation to be given to teacher in meeting the child's family needs

FIGURE 11

PSYCHOLOGICAL DIAGNOSTIC SUMMARY

STUDENT _____ DOB _____ CA _____

TEACHER _____ SCHOOL _____ AM __ PM ____

DATE OF EVALUATION _____ DISTRICT _____ COUNTY _____

DATE OF ENTRY _____

BEHAVIOR (Social & Testing):

Behavior during testing
Interaction with testers
Attention span
Acceptance or refusal to do tasks

COGNITIVE FUNCTIONING:

Qualitative information as measured by intelligence test (verbal subtests)

PERCEPTUAL FUNCTIONING:

Same as above (performance subtests)

PLAY BEHAVIOR/CLASSROOM OBSERVATION:

Observation of child's interaction with manipulative toys
Clinician's or teacher's input about child's interaction with peers

IMPRESSIONS:

Statement of strengths, special needs, and diagnosis

RECOMMENDATIONS:

Consultation to be given to teacher to aid in work with the child.

FIGURE 12

SPEECH & LANGUAGE DIAGNOSTIC SUMMARY

STUDENT _____ DOB _____ CA _____

TEACHER _____ SCHOOL _____ AM __ PM ____

DATE OF EVALUATION _____ DISTRICT _____ COUNTY _____

DATE OF ENTRY _____

PERTINENT HISTORY:

A. Medical history
B. Family history
C. General description of child's behavior, likes and dislikes, as well as impressions of child's interaction with family members

LANGUAGE:

Language Skills --Prelanguage skills as well as language skills (including content, form and use) are evaluated

Auditory Skills --Based on the child's behavior, speech and language skills, and history, it should be determined if an auditory disorder is a possible contributing factor and if formal auditory testing should be recommended

SPEECH SKILLS:

Intelligibility of speech is examined and a determination is made as to contributing interfering factors

PERIPHERAL SPEECH SYSTEM:

The speech mechanism is examined, and structural and functional disorders are noted to determine if they are significant in contributing to overall speech/language profile

CLASSROOM OBSERVATIONS:

Statement of the child's behavior during evaluation and in classroom including attention span, eye contact, use of toys, response to adults

IMPRESSIONS:

Statement of strengths and special needs

RECOMMENDATIONS:

Impressions and recommendations are made based on the child's total profile. Descriptions of how the speech and language skills of the child relate to other developmental levels are included.

FIGURE 13

EDUCATIONAL DIAGNOSTIC SUMMARY

STUDENT _____ DOB _____ CA _____

TEACHER _____ SCHOOL _____ AM __ PM ____

DATE OF EVALUATION _____ DISTRICT _____ COUNTY _____

DATE OF ENTRY INTO PROGRAM _____

PROGRESS AND PRESENT LEVEL OF FUNCTIONING:

A. Progress since placement in program
B. Present level of functioning in--
   1. social-emotional development
   2. speech and language development
   3. cognitive and motor development

CLASSROOM BEHAVIOR:

Skills
Attention span
Interaction with peers

IMPRESSIONS:

Statement of strengths and special needs

RECOMMENDATIONS:

For classroom program and parent involvement

CONSULTATIONS

When working with individual children, the teacher may often find him - or herself in need of skills possessed by a member of the team. When the team member works with the teacher on the development of particular skills for use with a particular child—he or she is providing "consultation."

Given team members' limited time, their knowledge and skills could be most effective if used to train the teacher who is responsible for implementing the IEP.

In a sense, the clinical team member's role becomes consultant rather than practitioner. It is important that each clinical member recognize that he or she is not the only person who can perform the functions usually associated with his or her profession.

"Role release" does not mean that the speech therapist, psychologist or social worker are supposed to relinquish all of their responsibilities to the teacher. It does mean that they help the teacher extend his or her own responsibilities; they train him or her to do certain specialized tasks with the children that they themselves do not have time to perform.

"Role release" by the psychologist and speech therapist may be accomplished by modeling the behavior, observing the teacher in the same activity, and providing feedback. For example, the speech therapist may demonstrate expanding a child's language in a play situation and discuss the emerging forms that should be modeled for the child. The psychologist may demonstrate techniques to develop specific age-appropriate social-emotional skills such as peer interaction. The social worker may suggest family intervention methods to the teacher and support him or her in using them.

This consultation approach can also be used by the teacher to train aides in "diagnostic teaching" and "individualizing instruction." Aides may

also receive training in the daily routine and the principles of child development. With this training, they are able to conduct a typical classroom program when teachers are absent or involved in child assessments.

It may be necessary for teachers within preschool programs to leave the classroom for several hours one day per week to perform school liaison activities, conduct parent-group meetings, meet with individual parents and investigate school-age placements for graduating students. The speech therapist and teacher aide may then be called upon to conduct the typical daily program. This means that the teacher releases his or her role as classroom manager for that time period. He or she may have prepared the therapist and aide by demonstrating educational techniques with large and small groups and with individuals.

Team members may also act as consultants in other ways--depending upon the time they have to provide services in the program.

At the first team meeting, everyone should be asked to develop a list of possible roles for themselves in the program. These roles may, of course, change depending upon program needs. Figure 14 shows the way time may be used for a social worker who is available one day per week. Figures 15 and 16 show how the psychologist and speech pathologist's time might be used.

Consultation is an ongoing process which requires commitment on the part of staff members to communicate their knowledge of assessment and intervention techniques, and a willingness on their part to accept and utilize this information. Consultation fosters mutual trust and respect.

FIGURE 14

ALLOCATION OF SOCIAL WORKER'S TIME

Activity	Time per Week	Month
Team meetings	one hour	All year
Transdisciplinary assessments	three hours	September to November
Parent IEP meetings	one hour	
Agency contacts		
1. written 2. phone 3. personal	one to three hours	December to April
Consultation with teacher regarding family needs	one hour	December to April
Classroom time for observation and interaction with children	one hour	December to March
Mothers' group (small, special-interest parent-group meetings)	one hour	December to April
Parent counseling	two hours	Throughout year--as needed
Referrals to school-age placements	one hour	April to June
Home visits	one hour	As needed

FIGURE 15

ALLOCATION OF PSYCHOLOGIST'S TIME

Activity	Time per Week	Month
Team meetings	one hour	All year
TD assessments	three hours	September to
Parent IEP meetings	one-two hours	November
Child observations	one hour	
Teacher consultation	one hour	December
Interaction with children	one hour	to
Parent counseling	two hours	March
Post assessments	three hours	April to
Referrals to school-age placements	two hours	June

FIGURE 16

ALLOCATION OF SPEECH PATHOLOGIST'S TIME

Activity	Time per Week	Month
Team meetings	one hour	All year
TD assessment	three hours	September to
Parent conferences	two hours	November
Child observations	one hour	December to
Teacher consultation	two hours	March
Direct therapy	three days per week	Throughout year
Conduct parent-group meeting	(two meetings per year:	December, March)
Post assessments	three hours	April to
Referrals to school-age placements	two hours	June

CHAPTER IV

TWO-YEAR IMPLEMENTATION PLAN

This section focuses on the time line of activities of the transdisciplinary approach. A two-year time line is shown in Figure 17. The time line is based upon a transdisciplinary team which meets once a week to evaluate twenty children. In programs in which the team meets more often or serves fewer children, several of the second year activities (see Activities 13-17 in Figure 17) can be conducted during the first year.

INITIAL TRANSDISCIPLINARY ACTIVITIES

First year activities, shown in Activities 1-10 in Figure 17, have been described in Chapters One through Three. These activities must be conducted to initiate the transdisciplinary approach. During the first year, a program should form a transdisciplinary team, develop an assessment process and instruments, provide ongoing training to the staff, and provide consultation to teachers.

Since team members meet only once a week, most of their time is spent in conducting assessments and conferencing with parents. Child observations within the classroom will occur as prioritized by the teacher, when the assessment schedule warrants. For example, a teacher may request the psychologist to observe a child's peer interaction during free play if the child has begun to consistently react disruptively. Child observations may also be scheduled to provide more assessment information to team members.

TIME LINE OF ACTIVITIES

Activities	Year 1											Year 2			
	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	Sept. Nov.	Dec. Feb.	Mar. May	June
1. Hire staff (formation of team)	X	X										X			
2. Develop assessment process and instruments		X	X									X			
3. Initial training session		X													
4. Child assessments		X	X	X					X	X		X		X	
5. Case conferencing		X	X	X	X	X	X	X	X	X	X	X		X	
6. Parent conferencing		X	X	X		X			X	X	X	X		X	
7. In-service training				X		X		X		X			X	X	
8. Consultation (role-release)					X	X	X	X	X			X	X	X	X
9. End-of-year evaluation											X				X
10. Child observation					X				X			X	X	X	X
11. Revision of model according to team input											X				X
12. Revision of Identification Procedures											X				
13. Revision of assessment process and instruments												X			
14. Development of small, special - interest parent groups												X			
15. Team visits to local programs or agencies serving specail needs children													X	X	
16. Team visits to school-age placements														X	
17. Additional continuous parent conferences												X	X	X	X

FIGURE 17

TIME LINE OF ACTIVITIES

REVISION ACTIVITIES

Revision of Model according to Team Input

At the end of the first year, the transdisciplinary model should be evaluated and revised according to team recommendations. The staff may use the end-of-year evaluation workshop for this purpose (see Figure 7, p. 34). The screening approach and TD report forms should also be reviewed at this time. A pre-entry transdisciplinary assessment may also be planned at the end of year one; it can be used during the second year as an additional diagnostic measure.

Revision of Identification Procedures

The process explained in Chapter III may be used successfully in several activities of a preschool program. We have found it successful in our screening process and in the pre-entry evaluation of children. The screening process, of course, is conducted with all referred children to identify those preschoolers who seem to have developmental difficulties that need further examination. This "further examination" is the diagnostic evaluation described in Chapter III. The pre-entry evaluation is used to determine an interim placement for new students who have gone through screening and show a need for further professional evaluation. This assessment is used with those students for whom an immediate diagnostic evaluation cannot be scheduled.

Screening. The "arena evaluation" technique works well with screening procedures. In fact, ten children can be screened in a day, with each screening lasting thirty to forty-five minutes.

The speech pathologist and psychologist screen the child for problems in speech and language, cognitive, and motor abilities; while the social worker

and teacher interview the parent and explain the screening process to him or her. The Denver Developmental Screening Test may be used. Releases to gather information from involved agencies are also obtained from the parent. Intake meetings in which screening summary reports are written and recommendations are discussed follow the evaluations. A sample screening form is shown in Figure 18.

Pre-Entry Transdisciplinary Assessment (PETD). This is, in fact, a shortened form of the evaluation discussed in Chapter III. As stated above, the purpose for this evaluation is to obtain a diagnosis for a child who, it is assumed from the screening process, is in need of a special program, but for whom a diagnosis has not yet been determined. An educational or medical diagnosis is often required for placement in early childhood special education programs. This diagnosis is especially important for children in our program because all of our clients must receive a classification of "handicapping condition" based on New York State's Commissioner's Regulations before receiving our services.

The following procedures for the PETD have been developed:

1. The team reviews screening records. The social worker obtains all known information from other agencies before the evaluation date.
2. Three evaluations are scheduled per day.
3. The social worker focuses on the reason for referral, relevant home and/or school behavior, and the meducal/developmental history. He or she explains the school's entry criteria to the parent.
4. The psychologist and speech and language pathologist conduct an abbreviated psychological evaluation and observe and record language.

FIGURE 18

PRESCHOOL PROGRAM

SCREENING SUMMARY

PASS _____

WAIT/WATCH _____

ACCEPT x

FOLLOW-UP DIAG. ____

NAME Child DOB 6/2/77 CA 3-6 SCREEN. DATE 11-20-80

ADDRESS _____ DISTRICT _____ COUNTY _____

PARENT (S) _____ PHONE _____

X NATURAL __ STEP __ FOSTER __ ADOPTIVE __ INSTI. __ SINGLE __ GRANDPARENT

REASON FOR REFERRAL Shyness--Mother Reports SOURCE OF REFERRAL _____

PARENT INTERVIEW INFORMATION:

Background Information: Child is the third child of four daughters. Older sister is presently enrolled in BOCES Preschool class in Mahopac. Child would not talk to the neurologist who saw her recently and who diagnosed her seizures as normal breath holding spells. Child was jaundiced at birth, was hospitalized twice during her first year, once for "failure to thrive" and a few weeks later for a cold that was developing into pneumonia. Child walked at 18 months, said Da-Da at ten months and put words together at two years. Child is extremely shy, mother reports. When she has a "seizure," she loses control of bodily functions and will lose consciousness at these times.

BEHAVIOR OBSERVED: Initially withdrawn, but as she became more involved with tasks, became increasingly distracted by the materials. Unable to comply with adult requests; pursued activities of her own choosing.

STRENGTHS: Expressive language content and use appear generally age-appropriate.

WEAKNESSES: Expressive language form appears slightly delayed; refused some receptive language tasks on Denver Screening. Fine Motor Skills: imitated vertical line only marginally; unable to copy circle. Refused most gross motor tasks; unable to throw ball overhand.

IMPRESSIONS: Possibly physically handicapped, dependent on medical information.

RECOMMENDATIONS:

1) Obtain medical information - neurological.

2) Accept into classroom program after determination of diagnosis has been made based on medical information.

Preschool Screening Team

5. An interim diagnosis of the child's needs is reached. This diagnosis and any outstanding results are discussed briefly with the parents at the end of the session. Upon entry into the program, further evaluations of the child's cognitive, language, and play skills occur. Behavior in the classroom is also considered. Further individual evaluations may be necessary. The social-work evaluation is then completed, and other team members meet with parents to report further evaluation results as necessary.
6. The teacher explains her classroom program to the parents and arranges a classroom visit.
7. One report signed by all team members is written.

A sample PETD is shown in Figure 19.

Revision of Assessment Process and Instruments

Programs should use the suggestions given during the TD evaluation workshop to revise their assessment process and instruments during the beginning of year two. Summary report forms may be changed to include more comprehensive information. Programs may decide to review and expand upon assessment instruments, include formal child observations for each assessment, conduct home visits to extend the parent interview or make other changes to determine the total needs of children.

ADDITIONAL TEAM ACTIVITIES

Activities 14-17 in the time line (see Figure 17), refer to additional team activities that are commonly initiated in the second year. There is usually limited time during the first year to conduct these activities, since teams are involved in assessment and parent conferencing.

FIGURE 19

PRE-ENTRY TRANSDISCIPLINARY ASSESSMENT

NAME_____ DOB_____ C.A._____

DATE_____ DISTRICT_____ COUNTY_____

BACKGROUND INFORMATION: Mrs. A. brought child to the preschool program upon the recommendation of the teacher of the play group which he attended. They were concerned about his behavior and questioned his skill development.

SUMMARY OF ASSESSMENT: Child was involved with tasks, cooperative and interacted well with the examiners. He functioned within the low-average range on the Stanford-Binet Intelligence Scale, Form L-M. There was significant scatter in his test performance. His earliest failure was on the picture naming task. It appears that word-finding difficulties affected his performance. For example, he named a key "a car thing," but later immediately named it correctly when given a key. He also said "a thing you put on your head when it rains" for umbrella. Other examples include "thing" for bird, "legs, toes" for foot, "table" for chair (then said "no, a chair"), "it says time" for clock, and demonstrated a five-second latency before naming box. A discrepancy in the comprehension of function as demonstrated in that child reliably did not point to umbrella when asked "what do you carry when it rains?", but described an umbrella with that definition when asked to name it.

Spontaneous language skills during play appeared to be age appropriate. Play skills also indicated good cognitive development: he was able to role play, changing voices with each character, and was able to manipulate the objects in a sequence of activities.

DIAGNOSTIC IMPRESSIONS: Specific Learning Disability.

RECOMMENDATIONS:

1) Enrollment in BOCES preschool classroom program in Fall of 1980.

2) Offer supportive services of program staff to mother. Continue to encourage the positive aspects of the interaction with child that Mrs. A. already demonstrates.

Development of Special-Interest Parent Groups

During the second year, team social workers or psychologists may identify several parents with common needs and develop small parent support groups to meet once monthly. These groups generally consist of three or four parents who may need additional conferencing to deal more effectively with their child's special needs. Parents in these groups share ideas and successful parenting methods to support each other in coping with their children's handicaps.

Team Visits to Local Programs and Agencies

During the second year, teams have the opportunity to visit local programs or agencies which serve special needs children. These visits enable teams to identify local programs that can provide additional medical, social services or therapeutic services, to meet a child's total needs. Teams also visit other programs to determine the most appropriate placement for graduates. Teams can then make recommendations to local education agencies based on their survey of local programs. See Figure 17, (Activities 15 and 16) for suggested months for initiating these visits.

Continuous Parent Conferences

Several parents may be identified in the second year who are in need of individual conferencing. One team member should be identified who will meet with specific parents continuously throughout the year. For example, the social worker may identify a parent who has reported significant family stress and who has expressed interest in speaking about these problems. Parent conferences may be conducted at school or during frequent home visits.

Programs should identify additional second year activities depending on child, family and program needs.

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APPENDIX A

JOB DESCRIPTIONS

FOR THE TD TEAM

JOB DESCRIPTION:

SOCIAL WORKER/FAMILY LIAISON

1) Meet the parents during screening and transdisciplinary assessment to obtain family history and other pertinent information.
2) Describe program and transdisciplinary assessments to parents.
3) Make recommendations to parents about appropriate programs for their child.
4) Train other team members in the techniques of family liaison.
5) Make referrals to appropriate agencies for parents.
6) Participate in selected special-interest parent group meetings.
7) Participate in selected IEP planning conferences.
8) Participate in staff conferences and provide input into IEP's.
9) Consult with teacher and teacher aide regarding child's family needs.
10) Provide reports to agencies who are working with a child.
11) Define school services to agencies.
12) Describe Pre-Entry Transdisciplinary Assessments to parents.
13) Make recommendations for teachers in working with parents.

JOB DESCRIPTION:

SCHOOL PSYCHOLOGIST

1) Train team members in psychological evaluations.

2) Screen, diagnose, and participate in transdisciplinary assessments of children referred to the program.

3) Write reports.

4) Conference with parents re: child diagnoses and needs.

5) Consult with teachers and make recommendations as to appropriate program and management of children.

6) Participate in team conferences and provide input into Individualized Educational Programs (IEP's).

7) Consult with child's school districts re: appropriate placement when child is school age.

8) Attend District Committee on the Handicapped meetings.

9) Perform post-testing on children in program.

10) Participate in selected IEP planning conferences.

11) Provide teachers with observation data (re: student behavior), and prescribe intervention strategies based on this data.

12) Consult with area nursery schools.

JOB DESCRIPTION:

SPEECH AND LANGUAGE THERAPIST

1) Train staff members in speech and language development.
2) Screen and diagnose speech and language of children referred to project.
3) Assess child with transdisciplinary team.
4) Write diagnostic reports.
5) Consult with parents about diagnoses and needs.
6) Consult with teachers and teacher's aide and make recommendations regarding appropriate programming for children.
7) Participate in staff conferences and IEP development.
8) Write IEPs for children in speech and language.
9) Perform post-testing on children in program.
10) Participate in selected IEP planning conferences.
11) Provide therapy to certain children through the use of a parent training model (in-home program).
12) Coordinate speech and language services with local clinics.
13) Consult with area nursery schools.
14) Attended Committee On The Handicapped meetings when necessary.
15) Provide direct intervention within classroom setting.
16) Participate in selected parent-group meetings.

JOB DESCRIPTION:

EARLY CHILDHOOD TEACHER

1) Train team members in individualized instructional techniques.
2) Participate in transdisciplinary assessments.
3) Develop IEP for each child in classroom program, based on assessment.
4) Individualize classroom program.
5) Direct and train teacher aides.
6) Participate in case conferences.
7) Implement curriculum materials adopted or developed.
8) Conduct parent conferences.
9) Organize monthly parent groups and training.
10) Work with a liaison or appropriate personnel from the school district when referring a child to that district when school age.
11) Provide consultation to the speech therapist on the classroom's daily routine.
12) Supervise student teachers when appropriate.
13) Keep and obtain records necessary to data collection on students and parents.
14) Write and assess prescriptions for home training, where appropriate.
15) Consult with area nursery schools.

APPENDIX B

SAMPLE TD DIAGNOSIS

FORMS FOR ONE CHILD

TRANSDISCIPLINARY DIAGNOSIS

STUDENT Child DOB 4-5-77 CA 3-6

TEACHER _____ SCHOOL _____ AM __ PM X

DATE OF EVALUATION 9-23-80 DISTRICT _____ COUNTY _____

DATE OF ENTRY 9-3-80

EDUCATIONAL HISTORY: BOCES Preschool is the first educational environment child has been involved in; she is joined in the preschool by her identical twin.

DIAGNOSTIC SUMMARY: Child functioned within the low-average range on the short form of the Stanford-Binet Intelligence Scale, Form L-M. Her production and comprehension of language are delayed in terms of content and form; use of language is appropriate although the amount of language produced varies across situations. Child exhibits multiple articulation errors, often accompanied by rapid speech rate and somewhat immature vocal patterns. Her relatedness to adults and peers is immature and somewhat inconsistent.

HANDICAPPING CONDITION: Severely Speech and Language Delayed

RECOMMENDATIONS:

1) Increase appropriate social and play skills in the classroom and establish a toilet-training program for home and school.

2) Speech and language goals should focus on production of age-appropriate grammatical morphemes, comprehension of wh-questions, and articulation skills. Further assess receptive and expressive vocabulary and concepts.

3) Work with mother to encourage differentiation of each child's personality.

4) Refer for audiological evaluation.

SOCIAL WORK DIAGNOSTIC SUMMARY

STUDENT Child DOB 4-5-77 CA 3-6

TEACHER _____ SCHOOL _____ AM __ PM X

DATE OF EVALUATION 9-23-80 DISTRICT _____ COUNTY _____

DATE OF ENTRY 9-3-80

SUMMARY SOCIAL DEVELOPMENTAL HISTORY: Child and twin are the first children born to S (32) and F (35). The existence of twins was unknown all through pregnancy. The twins were born by C-Section following a long, sporadic labor. Mrs. G. developed toxemia also, due to deliver, again by C-Section on 10/11.

Regarding development, Mrs. G. recalls milestones as occurring w/in expected frames (please see parent questionnaire); speech, however, has been a concern of the pediatrician, Dr. X.

In describing the girls, Mrs. G. could not name any factors that have distinguished one child from the other. She reports that they completely resemble one another in skills, habits, personality traits and, almost, in looks. Mrs. G. reports that even when others cannot understand the girl's speech, they understand one another. No idiosyncratic language is reported however.

Mrs. G. spoke of her enjoyment in parenting the girls and seems receptive to working with the preschool staff to better understand the girl's needs.

IMPRESSIONS: It was unfortunate that Mr. G. was not available to offer his impressions about the girls. Mrs. G. appeared to be, understandably, concentrating on the imminent delivery of her baby. From this interview, a clear picture of parent/child interaction could not be properly ascertained. Future meeting may prove to be more fruitful.

RECOMMENDATIONS:

1) Offer mother's group involvement to Mrs. G. for opportunity to meet other mother's in program.

2) Encourage parents to approach and interact with each child individually in order to encourage some differentiation.

PSYCHOLOGICAL DIAGNOSTIC SUMMARY

STUDENT Child DOB 4-5-77 CA 3-6

TEACHER _____ SCHOOL _____ AM __ PM X

DATE OF EVALUATION 9-23-80 DISTRICT _____ COUNTY _____

DATE OF ENTRY 9-3-80

BEHAVIOR (SOCIAL AND TESTING): Child was very quiet during testing, verbalizations included some jargon. She tended to say that she didn't know answers, but could be encouraged to respond. Attention to tasks varied. Eye contact and response to her name were also inconsistent. Affective range appeared limited, when animated behaviors were frequently silly (e.g., greeting one of the other examiners by tapping her on the nose with a doll while grinning).

COGNITIVE FUNCTIONING: The short form of the Stanford-Binet Intelligence Scale, Form L-M was administered. A complete ceiling was not obtained, but the child appeared to function within the low-average range, demonstrating considerable scatter. All items were passed at year 2; 3/4 at year 2-6, 3, and 3-6; and 1/4 at years 4, 4-6 and 5; only one item at year 6 was attempted. Earliest failures involved expressive language items. This probably reflected some delay in language compounded by a reticence to respond. Inconsistencies in vocabulary and ability to answer simple wh questions were noted (see Speech and Language Diagnostic Summary). In number concepts child consistently gave one and two, but not three objects. She could maintain one-to-one correspondence when counting small groups (e.g., 5 objects) but not larger groups (e.g., 8-12 objects).

PERCEPTUAL FUNCTIONING: Child used both hands for pencil and paper tasks, holding the pencil or crayon lightly. She copied vertical and horizontal lines and a circle, and imitated a cross. Visual discrimination skills were age appropriate, and she was able to combine two parts to form a whole.

PLAY BEHAVIOR/CLASSROOM OBSERVATION: Child's play suggests age appropriate use of objects. She combined objects well and carried out sequences of events. Activities were sometimes narrated, although these verbalizations included considerable repetitions and had a sing-song quality.

In the clasroom, child generally plays by herself or with her twin sister and one other girl. Child tends to watch new activities before becoming involved and the extent of her attention to activities is not always clear. Initiation of peer interaction is limited; and play tends to be parallel.

IMPRESSIONS: Child functioned within the low-average range on the Short Form of the Stanford-Binet Intelligence Scale, Form L-M. Visual perceptual skills appeared age appropriate, while language appeared delayed. Social immaturity was also noted. Reticence to become involved was noted during testing and in the classroom. This may have lowered test performance.

RECOMMENDATIONS:

1) Further observe degree of task involvement after child has had a longer time to adjust to classroom.

2) Work on developing social interaction skills and increasing ability to initiate and actively participate.

3) Discuss ways of allowing differentiation from her twin sister with her parents.

SPEECH & LANGUAGE DIAGNOSTIC SUMMARY

STUDENT Child DOB 4-5-77 CA 3-6

TEACHER _____ SCHOOL _____ AM __ PM X

DATE OF EVALUATION 9-23-80 DISTRICT _____ COUNTY _____

DATE OF ENTRY 9-3-80

PERTINENT HISTORY: See Social Work Diagnostic Summary

LANGUAGE: Child exhibited no spontaneous language during the TD assessment; however when playing alone after the evaluation some spontaneous utterances were noted. Language analysis was based on a language sample recorded on 9-22-80 and on classroom observation. Child consistently demonstrated appropriate play with toys. Although her MLU of approximately 3.3 morphemes places her at about a 3-year level (Stage III, Brown), grammatical complexity is characteristic of an earlier level, with inconsistencies noted. For example, child did not produce some grammatical constructions expected at a Stage III level such as use of auxiliary verbs, irregular past tense verb forms, and use of wh-questions. However, occasionally she produced constructions expected at a higher lever (e.g., articles). In addition, lover-level jargoning was produced frequently in spontaneous conversation. Therefore, language form appears delayed with some age-appropriate constructions emerging occasionally. Insonsistencies were apparent in child's language content also. She had difficulty labeling common objects (e.g., "box") and pictures occasionally, but spontaneously labeled objects and their functions later. Her receptive vocabulary as measured by the Peabody Picture Vocabulary Test (Form A) was at a 2-7 level; on Form B she achieved a 3-6 level. Syntactical comprehension appeared delayed, e.g., inconsistent responses to wh-questions.

Child used language appropriately to request action, information, and permission; to respond to questions; and to describe ongoing actions during play. However, her frequency of lanugage use varied across situations. In terms of lanugage style, child's intonation patterns during play gave the impression of a younger child: i.e., she use a "sing-song" and/or "squeaky" vocal pattern.

SPEECH: Child's speech was unintelligible at times due to multiple articulation errors and intermittent rapid speech rate. This does not appear to be related to her jargoning behavior. Articulation errors consisted of sound and syllable additions, omissions, and substitutions (e.g., difficulties with voiced/voiceless distinctions) in single words and connected speech.

PERIPHERAL SPEECH SYSTEM: Adequate to support speech.

CLASSROOM OBSERVATIONS: Child's attention for people and classroom activities is inconsistent. During the evaluation session she responded to her name by turning towards the speaker after four repetitions. In the classroom she responds to her name more consistently and responds to questions after repeated questioning. She gives limited eye contact when initially engaged in individual or group situations. During group activities such as singing, finger-plays, etc., child visually attends intermittently but does not often participate. She expresses interest in novel toys several seconds after their initial presentation, then plays with them appropriately. She often plays independently (see psychological summary for description of play behavior) without verbalizing or apparent awareness of others nearby. However, she does appropriately play with her twin sister and/or another child in a small group.

IMPRESSIONS: Child's production and comprehension of language are delayed in terms of content and form, with comprehension delayed to a lesser degree relative to production. She uses language appropriately when playing and speaking to others. However, the amount of language produced varies across situations. She exhibits multiple articulation errors, often accompanied by rapid speech rate and somewhat immature vocal intonation patterns.

RECOMMENDATIONS:

1) Continue classroom placement. Speech and language goals should be directed towards the following during individual and group-play activities:
   a. futher assessment of receptive and expressive vocabulary and concepts.
   b. facilitating use of auxiliary verbs in present progressive in simple declarative sentences.
   c. appropriate voiceless distinction when producing initial consonants /t,k/.
   d. facilitating accurate responses to wh-questions.

EDUCATIONAL DIAGNOSTIC SUMMARY

STUDENT Child DOB 4-5-77 CA 3-6

TEACHER _____ SCHOOL _____ AM __ PM X

DATE OF EVALUATION 9-23-80 DISTRICT _____ COUNTY _____

DATE OF ENTRY 9-3-80

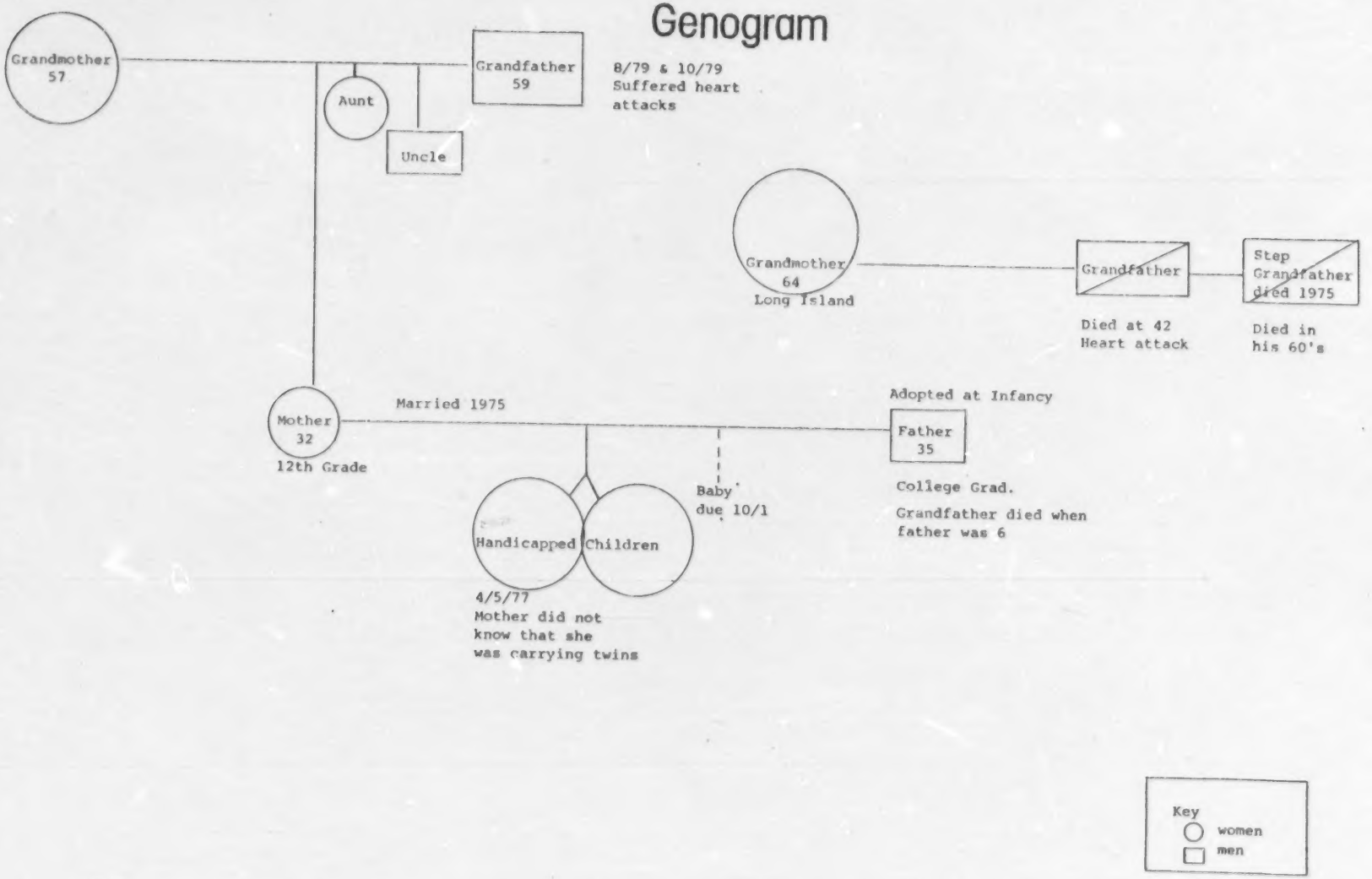
PROGRESS AND PRESENT LEVEL OF FUNCTIONING: Child's cognitive skills are generally age appropriate. She has an understanding of colors and numbers and comprehends basic concepts and directions. She needs to develop fine motor skills, specifically graphic motor tasks. Child needs work in classifying and matching patterns, identifying shapes and understanding the concept of same and different. Gross motor and most self-management skills are at age level. Child is not toilet trained, but appears to be developmentally ready for training. A home and school plan will be developed after new baby has arrived and family adjusts.

CLASSROOM BEHAVIOR: Child responds well to a group setting. She tends to play in certain areas of the room (doll house, kitchen) with her sister and one other special friend. She respond to direct questions after some delay in reaction time, but she does not use language while playing in a social setting.

IMPRESSIONS: Child is showing delays in use and form of language. Speech patterns are also delayed. Her relatedness to adults and peers is immature and somewhat inconsistent.

RECOMMENDATIONS: Structure classroom program to increase appropriate social and play skills. Develop use and form of language. Establish a toilet-training program for child a few weeks after mother and new baby have been home.

Genogram


Grandmother
57
Grandfather
59
8/79 & 10/79
Suffered heart
attacks
Aunt
Uncle
Grandmother
64
Long Island
Grandfather
Died at 42
Heart attack
Step
Grandfather
died 1975
Died in
his 60's
Mother
32
12th Grade
Married 1975
Adopted at Infancy
Father
35
College Grad.
Grandfather died when
father was 6
Baby
due 10/1
Handicapped Children
4/5/77
Mother did not
know that she
was carrying twins
Key
women
men

THE TRANSDISCIPLINARY MODEL MANUAL -

replacement pages for Appendix